WORKPLACE REQUIREMENTS PROGRAM FOR SAFETY AND HEALTH

FIRST AID LOG PAGE OF

FROM: (DATE)	DEPARTMENT/AGENCY:
TO: (DATE)	NAME/LOCATION:

DATE _____ TIME	Name	Age	Craft	S.S. Number	Immediate Supervisor	Injury/Illness	Description of Accident	Treatment Given By	LEGEND* _____ FAV RTW DV LTA
_____						_____	_____		
_____						_____	_____		
_____						_____	_____		
_____						_____	_____		
_____						_____	_____		
_____						_____	_____		
_____						_____	_____		
_____						_____	_____		

*FAV-First Aid Visit RTW-Return To Work DV-Doctor Visit LTA-Lost Time Accident